103D CONGRESS
1ST SESSION

S. 728

To provide for a comprehensive health care plan for all Americans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 1 (legislative day, MARCH 3), 1993

Mr. MCCONNELL introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To provide for a comprehensive health care plan for all Americans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive American Health Care Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—HEALTH CARE ACCESS FOR UNINSURED AND MEDICALLY UNDERSERVED INDIVIDUALS

Subtitle A—Tax Credits for Low and Moderate Income Individuals

SEC. 101. CREDIT FOR HEALTH INSURANCE EXPENSES.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable personal credits) is amended by inserting after section 34 the following new section:

"SEC. 34A. HEALTH INSURANCE EXPENSES.

''(a) ALLOWANCE OF CREDIT.—

''(1) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to—

''(A) the applicable percentage of the qualified health insurance expenses paid by such individual during the taxable year, less

''(B) the amount of the health insurance credit allowable to such individual for such taxable year under section 32.

''(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)—

"If adjusted gross income is:	The applicable percentage is:
Less than $25,000	70
$25,000 but less than $30,000	50
$30,000 but less than $35,000	30
$35,000 but less than $40,000	10
$40,000 or more	0.

''(b) QUALIFIED HEALTH INSURANCE EXPENSES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance expenses' means amounts paid during the taxable year for insurance which constitutes medical care (within the meaning of section 213(d)(1)(C)). For purposes of the preceding sentence, the rules of section 213(d)(6) shall apply.

''(2) DOLLAR LIMIT ON QUALIFIED HEALTH INSURANCE EXPENSES.—The amount of the qualified health insurance expenses paid during any taxable year which may be taken into account under subsection (a)(1) shall not exceed $2,500.

''(3) ELECTION NOT TO TAKE CREDIT.—A taxpayer may elect for any taxable year to have amounts described in paragraph (1) not treated as qualified health insurance expenses.

''(c) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means, with respect to any period, an individual who is not covered during such period by a health plan maintained by an employer of such individual or such individual's spouse.

''(d) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—

''(1) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If any payment is made to the individual under section 101(b) of the Comprehensive American Health Care Act during any calendar year, then the tax imposed by this chapter for the individual's last taxable year beginning in such calendar year shall be increased by the aggregate amount of such payments.

''(2) RECONCILIATION OF PAYMENTS ADVANCED AND CREDIT ALLOWED.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit (other than the credit al-

lowed by subsection (a)) allowable under this subpart.

''(e) SPECIAL RULES.—For purposes of this section—

''(1) MEDICARE-ELIGIBLE INDIVIDUALS.—No expense shall be treated as a qualified health insurance expense if it is an amount paid for insurance for an individual for any period with respect to which such individual is entitled (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act.

''(2) SUBSIDIZED EXPENSES.—No expense shall be treated as a qualified health insurance expense to the extent—

''(A) such expense is paid, reimbursed, or subsidized (whether by being disregarded for purposes of another program or otherwise) by the Federal Government, a State or local government, or any agency or instrumentality thereof, and

''(B) the payment, reimbursement, or subsidy of such expense is not includible in the gross income of the recipient.

''(3) COORDINATION WITH MINIMUM TAX.—Rules similar to the rules of subsection (h) of section 32 shall apply to any credit to which this section applies.

''(f) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) ADVANCE PAYMENTS OF CREDIT FOR SOME INDIVIDUALS.—

(1) IN GENERAL.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall enter into an agreement with each State to provide for advance payments of the credit provided by section 34A of the Internal Revenue Code of 1986 (as added by this subtitle) to eligible individuals in the form of certificates usable for the purchase of health insurance. The certificates shall be available at such locations as the Secretary determines will ensure the widest distribution.

(2) ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—An individual shall be eligible for advance payments described in paragraph (1) if such individual—

(i) has income for the taxable year which results in a poverty ratio of not more than 1.49, and

(ii) has filed a certificate with the Secretary of the Treasury or the Secretary's delegate described in subparagraph (C).

(B) POVERTY RATIO.—For purposes of subparagraph (A)(i), the poverty ratio for any individual shall be determined by dividing such individual's family income for the taxable year (as determined for purposes of title XIX of the Social Security Act) by the income official poverty line for such year (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(C) CERTIFICATE OF ELIGIBILITY.—A certificate described in this subparagraph is a statement furnished by the individual which—

(i) certifies that the individual will be eligible to receive the credit provided by section 34A of the Internal Revenue Code of 1986 for the taxable year,

(ii) certifies that the poverty ratio of the individual for such year will be not more than 1.49,

(iii) certifies that the individual does not have another certificate with respect to such credit in effect for such year,

(iv) estimates the amount of qualified health insurance expenses (as defined in section 34A(b) of such Code) for such year, and

(v) estimates the amount of health insurance credit under section 32 of such Code allowed for such year.

(c) PROGRAM TO INCREASE PUBLIC AWARENESS.—Not later than the first day of the first calendar year following the date of enactment of this Act, the Secretary of the Treasury, or the Secretary's delegate, in consultation with the Secretary of Health and Human Services, shall establish a public awareness program to inform the public of the availability of the credit for health insurance expenses allowed under section 34A of the Internal Revenue Code of 1986 (as added by this subtitle) and the coordination of such credit with the health insurance credit allowed under section 32 of such Code. Such public awareness program shall be designed to assure that individuals

who may be eligible are informed of the availability of such credit and filing procedures.

(d) COORDINATION WITH DEDUCTIONS FOR HEALTH INSURANCE EXPENSES.—

(1) SELF-EMPLOYED INDIVIDUALS.—Subparagraph (B) of section 162(l)(3) of the Internal Revenue Code of 1986 is amended by inserting ''or section 34A'' after ''section 32''.

(2) MEDICAL, DENTAL, ETC., EXPENSES.—Subsection (f) of section 213 of such Code is amended—

(A) by inserting ''or section 34A'' after ''section 32'', and

(B) by inserting ''OR SECTION 34A'' in the heading thereof after ''SECTION 32''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 34 the following new item:

''Sec. 34A. Health insurance expenses.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of enactment of this Act.

Subtitle B—Rural Health Initiatives

SEC. 111. ELIMINATION OF SEPARATE AVERAGE STANDARDIZED AMOUNTS FOR HOSPITALS IN DIFFERENT AREAS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end thereof the following new subsection:

''(j)(1) On or before September 1, 1993, the Secretary and the Prospective Payment Assessment Commission established under subsection (e) (in this subsection referred to as the 'Commission') shall each submit to the Congress a report recommending a methodology that provides for the elimination of the system of determining separate average standardized amounts for subsection (d) hospitals (as defined in subsection (d)(1)(B)) located in large urban, other urban, or rural areas under subsection (d)(2)(D). The methodologies set forth in such reports shall provide for the complete elimination of the average standardized amounts applicable to large urban, other urban, or rural area hospitals for discharges occurring on or after January 1, 1994. Such methodologies may provide for such changes to any of the adjustments, reductions, and special payments otherwise authorized or required by this section as the Secretary or the Commission deter-

mines to be necessary and appropriate to carry out the purposes of this subsection. But in no case may the Secretary or the Commission recommend or provide for a methodology that will result in total payments under part A of this title to hospitals at a level less than such hospitals were receiving on October 1, 1993.

''(2) Not later than October 1, 1993, the Secretary shall promulgate interim final regulations to implement the recommendations of the Secretary under paragraph (1) (including any recommended changes in the adjustments, reductions, and special payments otherwise authorized or required by this section).

''(3) If the Congress does not enact legislation after the date of enactment of this subsection and before December 1, 1993, with respect to the average standardized amounts applicable to large urban, other urban, or rural area hospitals, then, notwithstanding any other provision of this section, the average standardized amounts for such hospitals for discharges occurring on or after January 1, 1994, shall be determined in accordance with the interim final regulations promulgated under paragraph (2).

''(4) On or before July 1, 1994, the Secretary and the Commission shall each submit to the Congress a report specifying the manner in which the average standardized amounts determined under the regulations and which be-

came effective in accordance with paragraph (3) should be adjusted appropriately to reflect differences in the operating costs of providing inpatient hospital services (as defined in subsection (a)(4)) for different categories of subsection (d) hospitals.''.

SEC. 112. SCHOLARSHIP AND LOAN REPAYMENT PROGRAM PRIORITIES.

(a) SCHOLARSHIP PROGRAM.—Section 338A(d)(2) of the Public Health Service Act (42 U.S.C. 254l(d)(2)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end thereof;

(2) in subparagraph (C), by striking the period and inserting a semicolon; and

(3) by adding at the end thereof the following new subparagraphs:

''(D) fourth, to individuals who reside in health manpower shortage areas;

''(E) fifth, to disadvantaged individuals and minorities;

''(F) sixth, to individuals who attend or plan to attend health professions schools that have records of training graduates who then intend to work in primary care fields and with underserved populations;

''(G) seventh, to nurses, nurse midwives, nurse practitioners, and physician assistants to increase access to perinatal care; and

''(H) eighth, to physicians who are willing to serve in a Health Manpower Shortage Area that has been identified by the Corps as having difficulties in attracting physicians.''.

(b) LOAN REPAYMENT PROGRAM.—Section 338B(d)(2) of the Public Health Service Act (42 U.S.C. 254l–1(d)(2)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end thereof;

(2) in subparagraph (C), by striking the period and inserting a semicolon; and

(3) by adding at the end thereof the following new subparagraphs:

''(D) to applications from individuals who are legal residents of health manpower shortage areas or who, at the time of the submission of the application, reside in a health manpower shortage area;

''(E) to applications from disadvantaged individuals and minorities;

''(F) to applications from individuals who have demonstrated an interest in providing pri-

mary care service for the underserved through the participation of such individuals in internship and externship programs such as the commissioned officer, student training and extern program, and other programs;

''(G) to applications from nurses, nurse midwives, nurse practitioners, and physicians assistants to increase access to perinatal care and other essential primary care health services; and

''(H) to applications from physicians in the primary care fields of pediatrics, general internal medicine, general practice, and obstetrics and gynecology who are willing to serve in a health manpower shortage area that has been identified by the Corps as having difficulties in attracting such physicians.''.

SEC. 113. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by inserting after section 135 the following new section:

''SEC. 136. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(b) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 136 and inserting the following:

''Sec. 136. National Health Service Corps loan repayments.
''Sec. 137. Cross references to other Acts.''.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of enactment of this Act.

SEC. 114. DEMONSTRATION PROJECT TO EVALUATE AVAILABILITY OF PRENATAL CARE SERVICES IN RURAL AREAS.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall from amounts retained by the Secretary under section

502(b)(1)(A) of the Social Security Act (42 U.S.C. 702(b)(1)(A)) provide for a demonstration project evaluating the availability, accessibility, and use of prenatal care services by pregnant women residing in rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act).

(b) EFFECTIVE DATES.—(1) The Secretary shall conduct the demonstration project described in subsection (a) within 18 months of the date of enactment of this Act.

(2) The Secretary shall transmit a summary of the demonstration project conducted under subsection (a) to relevant committees of Congress no later than 3 months after the date of completion of such project as provided in paragraph (1).

SEC. 115. PREVENTIVE HEALTH SERVICES.

Part A of title XIX of the Public Health Service Act (42 U.S.C. 300w et seq.) is amended—

(1) in section 1901, by adding at the end thereof the following new subsection:

''(c) Of the amounts appropriated for each fiscal year under subsection (a), the Secretary shall make available not less than $25,000,000 in each such fiscal year to carry out section 1910A.''; and

(2) by adding at the end thereof the following new section:

''SEC. 1910A. PREVENTIVE GRANTS FOR COUNTY HEALTH DEPARTMENTS.

''(a) IN GENERAL.—From amounts made available under section 1901(c), the Secretary shall make grants to county health departments to enable such departments to provide preventive health services.

''(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a county health department shall prepare and submit, to the Secretary, an application at such time, in such form, and containing such information as the Secretary shall require.

''(c) USE OF FUNDS.—A county health department shall use amounts provided through a grant received under this section to—

''(1) provide immunization services to control the spread of infectious diseases;

''(2) improve maternal and infant health;

''(3) reduce adolescent pregnancy and improve reproductive health;

''(4) improve health education and the access of individuals to preventive health services; and

''(5) provide such other services as the Secretary determines appropriate.

''(d) DEFINITION.—Not later than 30 days after the date of enactment of this section, the Secretary shall pro-

mulgate regulations that define 'county health department' for purposes of this section.''.

SEC. 116. REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS.

(a) IN GENERAL.—Within 12 months of the date of enactment of this Act, the Secretary of Health and Human Services shall review the requirements in regulations developed pursuant to section 1861(e) of the Social Security Act to determine which requirements could be made less administratively and economically burdensome for hospitals defined in section 1886(d)(1)(B) of the Social Security Act that are located in a rural area as defined in section 1886(d)(2)(D) of the Social Security Act without diminishing the quality of care provided by such hospitals to individuals entitled to receive benefits under part A of title XVIII of the Social Security Act. Such review shall specifically include standards related to staffing requirements.

(b) REPORT.—The Secretary of Health and Human Services shall report to Congress by April 1, 1994, on the results of the review conducted under subsection (a), and include recommendations on which regulations if any, should be modified with respect to hospitals located outside a metropolitan statistical area as described in subsection (a).

SEC. 117. REVIEW OF EXISTING BARRIERS TO VOLUNTARY SERVICE BY PHYSICIANS IN UNDERSERVED AREAS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine any and all factors preventing or discouraging physicians (both active and retired) from volunteering to provide health care services in underserved areas.

(b) REPORTS.—

(1) INTERIM REPORT.—Within 18 months of the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under subsection (a).

(2) FINAL RECOMMENDATIONS.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit recommendations for actions to increase the number of physicians volunteering to provide health care services in medically underserved areas.

Subtitle C—Certified Model Health Care Insurance Benefits Plans

SEC. 121. MODEL HEALTH CARE INSURANCE BENEFITS PLANS.

(a) IN GENERAL.—Within 18 months of the date of enactment of this Act, the Secretary of Health and

Human Services (in this section referred to as the ''Secretary''), in conjunction with the National Association of Insurance Commissioners, business leaders, consumer advocates, and such other individuals possessing substantial knowledge or expertise in health care delivery, health care insurance, or health care economics, shall develop model health care insurance benefits plans.

(b) ELEMENTS OF PLANS.—The model benefits plans shall include—

(1) an affordable catastrophic health care insurance plan for basic hospital, medical, and surgical services;

(2) an affordable health care insurance plan for basic hospital, medical, and surgical services, including preventative care services deemed appropriate by the Secretary;

(3) reasonable cost sharing of beneficiaries under such plans; and

(4) appropriate co-payments and deductibles.

(c) CERTIFICATION.—

(1) IN GENERAL.—The Secretary shall no later than 6 months after the date of enactment of this Act establish a procedure certifying health insurance policies as meeting the standards and requirements set forth in this section.

(2) DURATION.—The certification described in paragraph (1) shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to verify independently the accuracy of such notarized statement. If the Secretary determines that such policy meets (or continues to meet) such standards and requirements, the Secretary shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may require) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification.

(3) LIST OF POLICIES CERTIFIED.—The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received certification under this section.

TITLE II—HEALTH CARE COST CONTROL

Subtitle A—Medical Malpractice Reform

SEC. 201. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) there are serious flaws in the civil justice system under which tort claims are filed and resolved, including spiraling costs, unpredictability, impediments to United States competitiveness and inefficient use of the civil justice system;

(2) the cost of litigation has risen at a dramatic rate over the past 25 years and threatens to continue to rise at a similar rate for the foreseeable future;

(3) the rising cost of litigation has a direct and undesirable effect on interstate commerce and international competitiveness, and decreases the availability of products and services in commerce;

(4) excessive litigation has contributed to health care inflation through defensive medical practices and the high cost of medical malpractice insurance accounting for an estimated $25,000,000,000 of the health care bill of the United States in 1987;

(5) the medical malpractice crisis has contributed to the diminution of the availability of health care across the country, particularly in rural areas;

(6) there is a need for reasonable limits on the potential exposure of health care providers to liability for damages resulting from the provision of medical services, which contributes to the availability of health care, the net output of the economy of the United States, to the American consumer, and the general welfare; and

(7) because of the interstate nature of commerce and the pervasive nature of the involvement of the Federal Government in the provision of health care, no single State can act to address flaws in the civil justice system without threatening to inflict disparate and potentially discriminatory burdens, thereby diminishing the general welfare of the Nation and of the several States.

(b) PURPOSE.—It is the purpose of this subtitle to establish uniform rules of medical malpractice law, to encourage alternate means of dispute resolution, to provide fair and reasonable compensation for accident or injury, and to promote the free flow of commerce and the availability and affordability of liability insurance.

SEC. 202. APPLICABILITY.

(a) IN GENERAL.—Except as provided in subsection (b) or (c), this subtitle shall apply to any civil action against any individual based on professional medical malpractice, in any State or Federal court, in which damages are sought for physical injury or for physical or mental pain or suffering or for economic loss.

(b) PREEMPTION.—This subtitle shall preempt and supersede Federal or State law only to the extent such law is inconsistent with this subtitle. Any issue arising under the provisions of this subtitle that is not governed by the provisions of this subtitle shall be governed by applicable State or Federal law.

(c) CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) supersede any Federal law, except the Federal Employees Compensation Act and the Longshoremen's and Harborworkers' Compensation Act;

(4) affect the applicability of any provision of chapter 97 of title 28, United States Code, com-

monly known as the Foreign Sovereign Immunities Act of 1976;

(5) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(6) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation on the ground of inconvenient forum.

(d) ATTORNEY'S FEES.—

(1) IN GENERAL.—Subject to paragraph (3), and except as provided in paragraph (2), in any action brought pursuant to the provisions of this subtitle, the court shall provide for an award of costs and reasonable attorney's fees to be paid to the prevailing party by the other parties to such action.

(2) EXCEPTION.—Paragraph (1) shall not apply in any case in which the losing party was qualified for assistance by the Legal Services Corporation, in the State in which such party resides, pursuant to the limits and guidelines described in part 1611 of title 45, Code of Federal Regulations.

(3) LIMITATION.—The amount of attorney fees ordered to be paid to the prevailing party under this subsection shall be limited to either—

(A) a percentage of the prevailing party's costs and fees equal to the percentage of any damage award such losing party had agreed to pay as a contingency fee to the attorney of such party if such party had prevailed, if the attorney for such losing party was to receive compensation based on a percentage of the recovery; or

(B) an amount that does not exceed the amount of attorney's fees such party is paying the attorney of such party in such matter, if the attorney for such losing party was not receiving compensation based on a percentage of the recovery.

SEC. 203. JOINT AND SEVERAL LIABILITY.

(a) IN GENERAL.—Except as provided in subsection (b), joint and several liability shall not be applied to a civil liability action that is subject to this subtitle. A person found liable for damages in any such action may—

(1) be found liable, if at all, only for those damages directly attributable to the pro rata share of fault or responsibility of such person for the injury; and

(2) not be found liable for damages attributable to the pro rata share of fault or responsibility of any

other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action.

(b) CONCERTED ACTION.—

(1) APPLICATION.—This section shall not apply as between persons acting in concert where the concerted action proximately caused the injury for which one or more persons are found liable for damages.

(2) DEFINITION.—As used in this section, the terms ''concerted action'' and ''acting in concert'' mean the participation in joint conduct by two or more persons who agree to jointly participate in such conduct with actual knowledge of the wrongfulness of the conduct.

SEC. 204. ALTERNATIVE DISPUTE RESOLUTION.

(a) POLICY.—Because the traditional litigation process is not always suited to the timely, efficient, and inexpensive resolution of civil actions, it is the policy of the United States to encourage the creation and use of alternative dispute resolution techniques, and to promote the expeditious resolution of such actions.

(b) EXISTENCE OF OPTIONS.—In any action to which this subtitle applies, each attorney who has made an appearance in the case and who represents one or more of

the parties to such action shall, with respect to each party separately represented, advise the party of the existence and availability of alternative dispute resolution options, including extrajudicial proceedings such as minitrials, third-party mediation, court supervised arbitration, and summary jury trial proceedings.

(c) CERTIFICATION.—Each attorney described in subsection (b) shall, at the time of the filing of the complaint or a responsive pleading, file notice with the court certifying that the attorney has so advised the client or clients of the attorney as required under subsection (b), and indicating whether such client will agree to one or more of the alternative dispute resolution techniques.

(d) ORDER GOVERNING FURTHER PROCEEDINGS.—If all parties to an action agree to proceed with one or more alternative dispute resolution proceedings, the court shall issue an appropriate order governing the conduct of such proceedings. The issuance of an order governing such further proceedings shall constitute a waiver, by each party subject to the order, of the right to proceed further in court.

SEC. 205. DEFINITIONS.

(a) DEFINITIONS.—As used in this subtitle:

(1) CLAIMANT.—The term ''claimant'' means any person who brings a civil action under this sub-

title, and any person on whose behalf such action is brought, and, if such an action is brought through or on behalf of an estate, such term includes the decedent of the claimant, or, if it is brought through or on behalf of a minor or incompetent, such term includes the parent or guardian of the claimant.

(2) HARM.—The term ''harm'' means any harm recognized under the law of the State in which the civil action is maintained.

(3) STATE.—The term ''State'' means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 206. EFFECTIVE DATE.

(a) IN GENERAL.—This subtitle shall become effective on the date of enactment of this Act, and shall apply to all civil actions filed on or after such date, including any civil action in which the harm or the conduct complained of occurred before such effective date.

(b) APPLICABLE TIME PERIOD.—If any such provision of this subtitle would shorten the period during which a person would otherwise be exposed to liability, the plain-

tiff may, notwithstanding the otherwise applicable time period, bring any civil action pursuant to this subtitle not later than within 1 year after the effective date of this subtitle.

SEC. 207. SEVERABILITY.

If any provision of this subtitle or the application of any such provision to any person or circumstance is held to be unconstitutional, the remainder of this subtitle and the application of the provisions of such to any person or circumstance shall not be affected thereby.

Subtitle B—Standardization of Claims Processing

SEC. 211. ADOPTION OF DATA ELEMENTS, UNIFORM CLAIMS, AND UNIFORM ELECTRONIC TRANSMISSION STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall adopt standards relating to each of the following:

(1) Data elements for use in paper and electronic claims processing under health benefit plans, as well as for use in utilization review and management of care (including data fields, formats, and medical nomenclature, and including plan benefit and insurance information).

(2) Uniform claims forms (including uniform procedure and billing codes for uses with such forms and including information on other health benefit plans that may be liable for benefits).

(3) Uniform electronic transmission of the data elements (for purposes of billing and utilization review).

Standards under paragraph (3) relating to electronic transmission of data elements for claims for services shall supersede (to the extent specified in such standards) the standards adopted under paragraph (2) relating to the submission of paper claims for such services. Standards under paragraph (3) shall include protections to assure the confidentiality of patient-specific information and to protect against the unauthorized use and disclosure of information.

(b) USE OF TASK FORCES.—In adopting standards under this section—

(1) the Secretary shall take into account the recommendations of current task forces, including at least the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force, and the Computer-based Patient Record Institute;

(2) the Secretary shall consult with the National Association of Insurance Commissioners (and, with respect to standards under subsection (a)(3), the American National Standards Institute); and

(3) the Secretary shall, to the maximum extent practicable, seek to make the standards consistent with any uniform clinical data sets which have been adopted and are widely recognized.

(c) DEADLINES FOR PROMULGATION.—The Secretary shall promulgate the standards under—

(1) subsection (a)(1) relating to claims processing data, by not later than 12 months after the date of enactment of this Act;

(2) subsection (a)(2) (relating to uniform claims forms) by not later than 12 months after the date of enactment of this Act; and

(3)(A) subsection (a)(3) relating to transmission of information concerning hospital and physicians services, by not later than 24 months after the date of enactment of this Act, and

(B) subsection (a)(3) relating to transmission of information on other services, by such later date as the Secretary may determine it to be feasible.

(d) REPORT TO CONGRESS.—Not later than 3 years after the date of enactment of this Act, the Secretary shall

report to Congress recommendations regarding restructuring the medicare peer review quality assurance program given the availability of hospital data in electronic form.

SEC. 212. APPLICATION OF STANDARDS.

(a) IN GENERAL.—If the Secretary determines, at the end of the 2-year period beginning on the date that standards are adopted under section 211 with respect to classes of services, that a significant number of claims for benefits for such services under health benefit plans are not being submitted in accordance with such standards, the Secretary may require, after notice in the Federal Register of not less than 6 months, that all providers of such services must submit claims to health benefit plans in accordance with such standards. The Secretary may waive the application of such a requirement in such cases as the Secretary finds that the imposition of the requirement would not be economically practicable.

(b) SIGNIFICANT NUMBER.—The Secretary shall make an affirmative determination described in subsection (a) for a class of services only if the Secretary finds that there would be a significant, measurable additional gain in efficiencies in the health care system that would be obtained by imposing the requirement described in such paragraph with respect to such services.

(c) APPLICATION OF REQUIREMENT.—

(1) IN GENERAL.—If the Secretary imposes the requirement under subsection (a)—

(A) in the case of a requirement that imposes the standards relating to electronic transmission of claims for a class of services, each health care provider that furnishes such services for which benefits are payable under a health benefit plan shall transmit electronically and directly to the plan on behalf of the beneficiary involved a claim for such services in accordance with such standards;

(B) any health benefit plan may reject any claim subject to the standards adopted under section 211 but which is not submitted in accordance with such standards;

(C) it is unlawful for a health benefit plan (i) to reject any such claim on the basis of the form in which it is submitted if it is submitted in accordance with such standards or (ii) to require, for the purpose of utilization review or as a condition of providing benefits under the plan, a provider to transmit medical data elements that are inconsistent with the standards established under section 211(a)(1); and

(D) the Secretary may impose a civil money penalty on any provider that knowingly and repeatedly submits claims in violation of such standards or on any health benefit plan (other than a health benefit plan described in paragraph (2)) that knowingly and repeatedly rejects claims in violation of subparagraph (B), in an amount not to exceed $100 for each such claim.

The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under subparagraph (D) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan—

(A) that is subject to regulation by a State, and

(B) with respect to which the Secretary finds that—

(i) the State provides for application of the standards established under section 211, and

(ii) the State regulatory program provides for the appropriate and effective enforcement of such standards.

(d) TREATMENT OF REJECTIONS.—If a plan rejects a claim pursuant to subsection (c)(1), the plan shall permit the person submitting the claim a reasonable opportunity to resubmit the claim on a form or in an electronic manner that meets the requirements for acceptance of the claim under such subsection.

SEC. 213. PERIODIC REVIEW AND REVISION OF STANDARDS.

(a) IN GENERAL.—The Secretary shall—

(1) provide for the ongoing receipt and review of comments and suggestions for changes in the standards adopted and promulgated under section 211;

(2) establish a schedule for the periodic review of such standards; and

(3) based upon such comments, suggestions, and review, revise such standards and promulgate such revisions.

(b) APPLICATION OF REVISED STANDARDS.—If the Secretary under subsection (a) revises the standards described in 211, then, in the case of any claim for benefits submitted under a health benefit plan more than the mini-

mum period (of not less than 6 months specified by the Secretary) after the date the revision is promulgated under subsection (a)(3), such standards shall apply under section 212 instead of the standards previously promulgated.

SEC. 214. HEALTH BENEFIT PLAN DEFINED.

In this subtitle, the term ''health benefit plan''—

(1) means—

(A) any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance subscriber contract,

(B) the medicare program (under title XVIII of the Social Security Act) and medicare supplemental health insurance, and

(C) a State medicaid plan (approved under title XIX of such Act), but

(2) does not include—

(A) accident-only, credit, dental, or disability income insurance,

(B) coverage issued as a supplement to liability insurance,

(C) worker's compensation or similar insurance, or

(D) automobile medical-payment insurance.

Subtitle C—Electronic Medical Data Standards

SEC. 221. MEDICAL DATA STANDARDS FOR HOSPITALS AND OTHER PROVIDERS.

(a) PROMULGATION OF HOSPITAL DATA STANDARDS.—

(1) IN GENERAL.—Between July 1, 1995, and January 1, 1996, the Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall promulgate standards described in subsection (b) for hospitals concerning electronic medical data.

(2) REVISION.—The Secretary may from time to time revise the standards promulgated under this subsection.

(b) CONTENTS OF DATA STANDARDS.—The standards promulgated under subsection (a) shall include at least the following:

(1) A definition of a standard set of data elements for use by utilization and quality control peer review organizations.

(2) A definition of the set of comprehensive data elements, which set shall include for hospitals

the standard set of data elements defined under paragraph (1).

(3) Standards for an electronic patient care information system with data obtained at the point of care, including standards to protect against the unauthorized use and disclosure of information.

(4) A specification of, and manner of presentation of, the individual data elements of the sets and system under this subsection.

(5) Standards concerning the transmission of electronic medical data.

(6) Standards relating to confidentiality of patient-specific information.

The standards under this section shall be consistent with standards for data elements established under section 211.

(c) OPTIONAL DATA STANDARDS FOR OTHER PROVIDERS.—

(1) IN GENERAL.—The Secretary may promulgate standards described in paragraph (2) concerning electronic medical data for providers that are not hospitals. The Secretary may from time to time revise the standards promulgated under this subsection.

(2) CONTENTS OF DATA STANDARDS.—The standards promulgated under paragraph (1) for non-

hospital providers may include standards comparable to the standards described in paragraphs (2), (4), and (5) of subsection (b) for hospitals.

(d) CONSULTATION.—In promulgating and revising standards under this section, the Secretary shall—

(1) consult with the American National Standards Institute, hospitals, with the advisory commission established under section 225, and with other affected providers, health benefit plans, and other interested parties, and

(2) take into consideration, in developing standards under subsection (b)(1), the data set used by the utilization and quality control peer review program under part B of title XI of the Social Security Act.

SEC. 222. APPLICATION OF ELECTRONIC DATA STANDARDS TO CERTAIN HOSPITALS.

(a) MEDICARE REQUIREMENT FOR SHARING OF HOSPITAL INFORMATION.—As of January 1, 1997, subject to paragraph (2), each hospital, as a requirement of each participation agreement under section 1866 of the Social Security Act, shall—

(1) maintain clinical data included in the set of comprehensive data elements under section 221(b)(2) in electronic form on all inpatients,

(2) upon request of the Secretary or of a utilization and quality control peer review organization (with which the Secretary has entered into a contract under part B of title XI of such Act), transmit electronically the data set, and

(3) upon request of the Secretary, or of a fiscal intermediary or carrier, transmit electronically any data (with respect to a claim) from such data set, in accordance with the standards promulgated under section 221(a).

(b) WAIVER AUTHORITY.—Until January 1, 2000:

(1) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is a small rural hospital, for such period as the hospital demonstrates compliance with such requirements would constitute an undue financial hardship.

(2) The Secretary may waive the application of the requirements of subsection (a) for a hospital that is in the process of developing a system to provide the required data set and executes agreements with its fiscal intermediary and its utilization and quality control peer review organization that the hospital will meet the requirements of subsection (a) by a specified date (not later than January 1, 2000).

(3) The Secretary may waive the application of the requirement of subsection (a)(1) for a hospital that agrees to obtain from its records the data elements that are needed to meet the requirements of paragraphs (2) and (3) of subsection (a) and agrees to subject its data transfer process to a quality assurance program specified by the Secretary.

(c) APPLICATION TO HOSPITALS OF THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall provide that each hospital of the Department of Veterans Affairs shall comply with the requirements of subsection (a) in the same manner as such requirements would apply to the hospital if it were participating in the medicare program.

(2) WAIVER.—Such Secretary may waive the application of such requirements to a hospital in the same manner as the Secretary of Health and Human Services may waive under subsection (b) the application of the requirements of subsection (a).

SEC. 223. ELECTRONIC TRANSMISSION TO FEDERAL AGENCIES.

(a) IN GENERAL.—Effective January 1, 2000, if a provider is required under a Federal program to transmit a data element that is subject to a presentation or trans-

mission standard (as defined in subsection (b)), the head of the Federal agency responsible for such program (if not otherwise authorized) is authorized to require the provider to present and transmit the data element electronically in accordance with such a standard.

(b) PRESENTATION OR TRANSMISSION STANDARD DEFINED.—In subsection (a), the term ''presentation or transmission standard'' means a standard, promulgated under subsection (b) or (c) of section 221, described in paragraph (4) or (5) of section 221(b).

SEC. 224. LIMITATION ON DATA REQUIREMENTS WHERE STANDARDS ARE IN EFFECT.

(a) IN GENERAL.—If standards with respect to data elements are promulgated under section 221 with respect to a class of provider, a health benefit plan may not require, for the purpose of utilization review or as a condition of providing benefits under the plan, that a provider in the class—

(1) provide any data element not in the set of comprehensive data elements specified under such standards, or

(2) transmit or present any such data element in a manner inconsistent with the applicable standards for such transmission or presentation.

(b) COMPLIANCE.—

(1) IN GENERAL.—The Secretary may impose a civil money penalty on any health benefit plan (other than a health benefit plan described in paragraph (2)) that fails to comply with subsection (a) in an amount not to exceed $100 for each such failure. The provisions of section 1128A of the Social Security Act (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(2) PLANS SUBJECT TO EFFECTIVE STATE REGULATION.—A plan described in this paragraph is a health benefit plan that is subject to regulation by a State, if the Secretary finds that—

(A) the State provides for application of the requirement of subsection (a), and

(B) the State regulatory program provides for the appropriate and effective enforcement of such requirement with respect to such plans.

SEC. 225. ADVISORY COMMISSION.

(a) IN GENERAL.—The Secretary shall establish an advisory commission including hospital executives, hospital data base managers, physicians, health services researchers, and technical experts in collection and use of data

and operation of data systems. Such commission shall include, as ex officio members, a representative of the Director of the National Institutes of Health, the Administrator for Health Care Policy and Research, the Secretary of Veterans Affairs, and the Director of the Centers for Disease Control.

(b) FUNCTIONS.—The advisory commission shall monitor and advise the Secretary concerning—

(1) the standards established under this subtitle, and

(2) operational concerns about the implementation of such standards under this subtitle.

(c) STAFF.—From the amounts appropriated under subsection (d), the Secretary shall provide sufficient staff to assist the advisory commission in its activities under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1994 through 1998 to carry out this section.

Subtitle D—Preventive Health Practices Promotion

SEC. 231. DISTRIBUTION OF INFORMATION ON RECOMMENDED PREVENTIVE HEALTH PRACTICES.

(a) IN GENERAL.—Section 1804 of the Social Security Act (42 U.S.C. 1396b–2) is amended—

(1) in the heading, by inserting ''AND DISTRIBUTION OF PREVENTIVE HEALTH INFORMATION'' after ''MEDICARE BENEFITS'';

(2) by inserting ''(a)'' after ''SEC. 1804.''; and

(3) by adding at the end the following new subsection:

''(b)(1) The Secretary shall develop (and, from time to time, shall revise) a summary of recommended preventive health care practices for elderly individuals entitled to benefits under this title.

''(2) The summary shall be developed in consultation with national physician, consumer, and other health-related groups and shall be based on recommendations of any appropriate task force or similar group established by the Secretary.

''(3) The Secretary shall provide for the distribution of—

''(A) the summary developed under paragraph (1) to each individual at the time of the individual's first becoming eligible for benefits under part A under section 226(a) or section 1818, as part of other materials sent to such an individual at such a time, and

''(B) the summary developed under paragraph (1) to individuals entitled to benefits under this title in conjunction with general mailings sent under this title to such individuals.''.

(b) DEVELOPMENT OF SUMMARY AND FORM.—The Secretary of Health and Human Services shall initially develop the summary described in section 1804(b) of the Social Security Act (as added by subsection (a)) not later than April 1, 1994, and shall first provide for the distribution of such summaries by not later than October 1, 1994.

TITLE III—LONG-TERM CARE AND SENIOR HEALTH PROMOTION

Subtitle A—Long-Term Care Insurance Promotion

SEC. 301. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

(a) GENERAL RULE.—Chapter 79 of the Internal Revenue Code of 1986 (relating to definitions) is amended by inserting after section 7702 the following new section:

"SEC. 7702A. TREATMENT OF LONG-TERM CARE INSURANCE OR PLANS.

''(a) GENERAL RULE.—For purposes of this title—

''(1) a long-term care insurance contract shall be treated as a health insurance contract,

''(2) amounts received under such a contract with respect to qualified long-term care services shall be treated as amounts received for personal injuries or sickness, and

''(3) any plan of an employer providing qualified long-term care services shall be treated as an accident or health plan.

''(b) LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title, the term 'long-term care insurance contract' means any insurance contract if—

''(1) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(2) such contract does not cover expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(3) such contract is guaranteed renewable,

''(4) such contract does not have any surrender value, and

''(5) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual in a qualified facility, and

''(B) are provided pursuant to a plan of care prescribed by a physician.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a physician as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in subparagraph (B)), or

''(ii) having a similar level of disability due to cognitive impairment.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) BATHING.—The overall complex behavior of getting water and cleansing the whole body, including turning on the water for a bath, shower, or sponge bath, getting to, in, and out of a tub or shower, and washing and drying oneself.

''(ii) DRESSING.—The overall complex behavior of getting clothes from closets and drawers and then getting dressed.

''(iii) TOILETING.—The act of going to the toilet room for bowel and bladder function, transferring on and off the toilet, cleaning after elimination, and arranging clothes.

''(iv) TRANSFER.—The process of getting in and out of bed or in and out of a chair or wheelchair.

''(v) EATING.—The process of getting food from a plate or its equivalent into the mouth.

''(3) QUALIFIED FACILITY.—The term 'qualified facility' means—

''(A) a nursing, rehabilitative, hospice, or adult day care facility, including a hospital, retirement home, nursing home, skilled nursing facility, intermediate care facility, or similar institution, licensed under State law, or

''(B) an individual's home if a physician, certifies that without home care the individual would have to be cared for in a facility described in subparagraph (A), except that such home shall be treated as a qualified facility only to the extent the cost of such services is not greater than the cost of similar services pro-

vided in a facility described in subparagraph (A).

''(4) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any service the primary purpose of which is to provide needed assistance with any of the activities of daily living described in paragraph (2)(B).

''(5) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 213(d)(4).''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 79 of such Code is amended by inserting after the item relating to section 7702 the following new item:

''Sec. 7702A. Treatment of long-term care insurance or plans.''.

SEC. 302. QUALIFIED LONG-TERM SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) of the Internal Revenue Code of 1986 (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 7702A(c)), or''.

(b) TECHNICAL AMENDMENT.—

(1) Subparagraph (D) of section 213(d)(1) of such Code (as amended by subsection (a)) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(2) Paragraph (6) of section 213(d) of such Code is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(3) Paragraph (7) of section 213(d) of such Code is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

SEC. 303. EMPLOYER PAYMENTS FOR LONG-TERM CARE INSURANCE NOT TREATED AS DEFERRED COMPENSATION.

(a) GENERAL RULE.—Subparagraph (B) of section 404(b)(2) of the Internal Revenue Code of 1986 (relating to plans providing certain deferred benefits) is amended to read as follows:

''(B) EXCEPTIONS.—

''(i) WELFARE BENEFIT FUNDS.—Subparagraph (A) shall not apply to any benefit provided through a welfare benefit fund (as defined in section 419(e)).

''(ii) PREMIUMS FOR LONG-TERM INSURANCE CONTRACTS.—

''(I) IN GENERAL.—Except as provided in subclause (II), subparagraph (A) shall not apply to any amount paid or incurred for any long-term care insurance contract.

''(II) EXCEPTION.—Subclause (I) shall not apply to any amount paid or incurred by the taxpayer during any taxable year to the extent such amount exceeds the premium which would have been payable under the contract for such year under a level premium structure.''.

(b) CAFETERIA PLANS.—Paragraph (2) of section 125(c) of such Code (relating to deferred compensation plans excluded) is amended by adding at the end thereof the following new subparagraph:

''(D) EXCEPTION FOR LONG-TERM CARE INSURANCE CONTRACTS.—For purposes of sub-

paragraph (A), amounts paid or incurred for any long-term care insurance contract shall not be treated as deferred compensation to the extent section 404(b)(2)(A) does not apply to such amounts by reason of section 404(b)(2)(B)(ii).''.

SEC. 304. LONG-TERM CARE INSURANCE TAX CREDIT.

(a) GENERAL RULE.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits), as amended by section 101, is amended by redesignating section 35 as section 36 and by inserting after section 34A the following new section:

''SEC. 35. LONG-TERM CARE INSURANCE CREDIT.

''(a) GENERAL RULE.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year an amount equal to applicable percentage of the qualified long-term care premiums paid during such taxable year.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a)—

''If adjusted gross income is:	**The applicable percentage is:**
Less than $25,000	70
$25,000 but less than $30,000	50
$30,000 but less than $35,000	30
$35,000 but less than $40,000	10
$40,000 or more	0.

''(c) DOLLAR LIMITATION ON AMOUNT DEDUCTIBLE.—

''(1) IN GENERAL.—The amount of the qualified long-term care premiums taken to account under subsection (a) for any taxable year shall not exceed the limitation determined under the following table:

"In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	$600
More than 40 but not more than 50	1,200
More than 50 but not more than 60	1,800
More than 60 but not more than 70	2,400
More than 70	3,000.

In the case of a joint return, the limitation of this paragraph shall be applied separately with respect to each spouse.

''(2) INDEXING.—

''(A) IN GENERAL.—In the case of any taxable year beginning after December 31, 1994, each dollar amount contained in paragraph (1) shall be increased by the medical care cost adjustment for such taxable year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(B) MEDICAL CARE COST ADJUSTMENT.—For purposes of subparagraph (A), the

medical care cost adjustment for any taxable year is the percentage (if any) by which—

''(i) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the calendar year preceding the calendar year in which the taxable year begins, exceeds

''(ii) such component for August of 1992.

''(d) QUALIFIED LONG-TERM CARE PREMIUMS.—For purposes of this section, the term 'qualified long-term care premiums' means the amount paid by the taxpayer during the taxable year for any long-term care insurance contract covering the taxpayer, but only to the extent the amount so paid does not exceed the premiums which would have been payable under the contract for such taxable year under a level premium structure.

''(e) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—

''(1) RECAPTURE OF EXCESS ADVANCE PAYMENTS.—If any payment is made to the individual under section 304(b) of the Comprehensive American Health Care Act during any calendar year, then the tax imposed by this chapter for the individual's last taxable year beginning in such calendar year

shall be increased by the aggregate amount of such payments.

''(2) RECONCILIATION OF PAYMENTS ADVANCED AND CREDIT ALLOWED.—Any increase in tax under paragraph (1) shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit (other than the credit allowed by subsection (a)) allowable under this subpart.

''(f) COORDINATION WITH MINIMUM TAX.—Rules similar to the rules of subsection (h) of section 32 shall apply to any credit to which this section applies.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) ADVANCE PAYMENTS OF CREDIT FOR SOME INDIVIDUALS.—

(1) IN GENERAL.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall enter into an agreement with each State to provide for advance payments of the credit provided by section 35 of the Internal Revenue Code of 1986 (as added by this subtitle) to eligible individuals in the form of certificates usable for the purchase of long-term care insurance. The

certificates shall be available at such locations as the Secretary determines will ensure the widest distribution.

(2) ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—An individual shall be eligible for advance payments described in paragraph (1) if such individual—

(i) has income for the taxable year which results in a poverty ratio of not more than 1.49, and

(ii) has filed a certificate with the Secretary of the Treasury described in subparagraph (C).

(B) POVERTY RATIO.—For purposes of subparagraph (A)(i), the poverty ratio for any individual shall be determined by dividing such individual's family income for the taxable year (as determined for purposes of title XIX of the Social Security Act) by the income official poverty line for such year (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(C) CERTIFICATE OF ELIGIBILITY.—A certificate described in this subparagraph is a statement furnished by the individual which—

(i) certifies that the individual will be eligible to receive the credit provided by section 35 of the Internal Revenue Code of 1986 for the taxable year,

(ii) certifies that the poverty ratio of the individual for such year will be not more than 1.49,

(iii) certifies that the individual does not have another certificate with respect to such credit in effect for such year, and

(iv) estimates the amount of qualified long-term care premiums (as defined in section 35(d) of such Code) for such year.

(c) PROGRAM TO INCREASE PUBLIC AWARENESS.—Not later than the first day of the first calendar year following the date of enactment of this Act, the Secretary of the Treasury, or the Secretary's delegate, in consultation with the Secretary of Health and Human Services, shall establish a public awareness program to inform the public of the availability of the credit for long-term care insurance expenses allowed under section 35 of the Internal Revenue Code of 1986 (as added by this subtitle).

Such public awareness program shall be designed to assure that individuals who may be eligible are informed of the availability of such credit and filing procedures.

(d) CLERICAL AMENDMENT.—The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the item relating to section 35 and inserting the following:

''Sec. 35. Long-term care insurance credit.
''Sec. 36. Overpayments of tax.''.

SEC. 305. EXEMPTION FROM 10-PERCENT ADDITIONAL TAX; CERTAIN EXCHANGES NOT TAXABLE.

(a) EXEMPTION FROM ADDITIONAL TAX.—

(1) IN GENERAL.—Paragraph (2) of section 72(t) of the Internal Revenue Code of 1986 (relating to additional tax not to apply to certain distributions) is amended by adding at the end thereof the following new subparagraph:

''(E) DISTRIBUTIONS USED TO PAY FOR LONG-TERM CARE INSURANCE CONTRACTS.—Any distribution made on or after the date on which the employee attains age 50 to the extent such distribution is used, not later than the day 60 days after the day on which such distribution is made, to pay premiums on a long-term care insurance contract for such employee.''.

(2) TECHNICAL AMENDMENT.—Subparagraph (B) of section 72(t)(2) of such Code is amended—

(A) by striking ''subparagraph (A) or (C)'' and inserting ''subparagraph (A), (C), or (E)'',

(B) by adding at the end thereof the following new sentence: ''For purposes of the preceding sentence, any premiums paid on a long-term care insurance contract shall not be treated as paid for medical care to the extent such premiums are taken into account under subparagraph (E).''.

(b) CERTAIN EXCHANGES NOT TAXABLE.—Subsection (a) of section 1035 of such Code (relating to certain exchanges of insurance contracts) is amended by striking the period at the end of paragraph (3) and inserting ''; or'', and by adding at the end thereof the following new paragraph:

''(4) in the case of an individual who has attained age 50, a contract of life insurance or an endowment or annuity contract for a long-term care insurance contract.''.

SEC. 306. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to taxable years beginning after the date of enactment of this Act.

Subtitle B—Medicare Benefit Improvements

SEC. 311. IN-HOME RESPITE CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) of the Social Security Act (42 U.S.C. 1395k(a)) is amended—

(1) in paragraph (2)(A)—

(A) by inserting ''(i)'' after ''(A)'', and

(B) by inserting before the semicolon at the end the following: '', and (ii) in-home respite care for a chronically dependent individual for up to 80 hours in any 12-month period described in section 1861(kk)(4), but not to exceed 80 hours in any calendar year''; and

(2) by adding at the end the following new sentence:

''In the case of in-home respite care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.''.

(b) IN-HOME RESPITE CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by inserting after subsection (jj) the following new subsection:

''In-Home Respite Care; Chronically Dependent Individual

''(kk)(1) The term 'in-home respite care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

''(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

''(B) Personal care services.

''(C) Nursing care provided by a licensed professional nurse.

''(2) The term 'chronically dependent individual' means an individual who has been certified by a physician as—

''(A) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living (as defined in paragraph (3)), or

''(B) having a similar level of disability due to cognitive impairment.

''(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

''(i) Eating.

''(ii) Bathing.

''(iii) Dressing.

''(iv) Toileting.

''(v) Transferring in and out of a bed or in and out of a chair.

''(4)(A) The 12-month period described in this paragraph is the 1-year period beginning on the date that the Secretary determines that a chronically dependent individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (5)(A)) in an amount equal to the part B limit (as determined under paragraph (5)(B)) for the year.

''(B) In the case of an individual who qualifies under subparagraph (A) within 12 months after previously qualifying, the subsequent qualification shall begin a new 12-month period under this paragraph.

''(5) For purposes of this subsection:

''(A) The term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under part B, the amounts of expenses that the individual incurs that are attributable to—

''(i) the deductions established under section 1833(b), and

''(ii) the difference between the payment amount provided under part B and the payment amount that would be provided under part B if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in sections 1833(a), 1833(i)(2), 1834(c)(1)(C), 1835(b)(2), 1866(a)(2)(A), 1881(b)(2), and 1881(b)(3).

''(B)(i) The part B limit for 1994 is $1,780. The part B limit for any succeeding year shall be such an amount (rounded to the nearest multiple of $1) as the Secretary estimates, for that succeeding year, will reflect a level of out-of-pocket part B expenses that only 5.5 percent of the average number of individuals enrolled under part B (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) will equal or exceed in that succeeding year.

''(ii) Not later than September 1 of each year (beginning with 1994), the Secretary shall promulgate the part B limit under this subparagraph for the succeeding year.''.

(c) PAYMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting ''(A)(ii),'' after ''subparagraphs'' the first place it appears,

(2) in paragraph (3), by striking ''(D)'' and inserting ''(A)(ii), (D),'', and

(3) by adding at the end the following:

''Payment for in-home respite care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home respite care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.''.

(d) CERTIFICATION.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended—

(1) in subparagraph (E), by striking ''and'' at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by inserting after subparagraph (F) the following new subparagraph:

''(G) in the case of in-home respite care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.''.

(e) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (E), by striking ''and'' at the end,

(ii) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

(iii) by adding at the end the following new subparagraph:

''(G) in the case of in-home respite care for chronically dependent individuals, which is not reasonable and necessary to assure the health and con-

dition of the individual is maintained in the individual's noninstitutional residence;''; and

(B) in paragraph (6), by inserting ''and except, in the case of in-home respite care, as is otherwise permitted under paragraph (1)(G)'' after ''paragraph (1)(C)''.

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home respite care for chronically dependent individuals under the amendments made by this section.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1994.

SEC. 312. COVERAGE OF HOME INTRAVENOUS DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) of the Social Security Act (42 U.S.C. 1395k(a)(2)(A)), as amended by section 311(a) of this Act, is further amended—

(1) by striking '', and (ii)'' and inserting '', (ii)''; and

(2) by striking ''calendar year'' before the semicolon and inserting '', calendar year, and (iii) home intravenous drug therapy services''.

(b) HOME INTRAVENOUS DRUG THERAPY SERVICES DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x), as amended by section 311(b) of this Act, is further amended by adding at the end the following new subsection:

''Home Intravenous Drug Therapy Services

''(ll)(1) The term 'home intravenous drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

''(A) in a place of residence used as such individual's home;

''(B) by a qualified home intravenous drug therapy provider (as defined in paragraph (4)) or by another person under arrangements with such person made by such provider; and

''(C) under a plan established and periodically reviewed by a physician.

''(2) The items and services described in this paragraph are such nursing, pharmacy, and related services and products (including pharmaceutical products, medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively an intravenously administered drug regimen through use of a covered home intravenous drug.

''(3)(A) The term 'covered home intravenous drug' means an approved drug dispensed to an individual that the Secretary of Health and Human Services has determined can generally be administered safely and effectively in a home setting.

''(B) Not later than January 1, 1994, and periodically thereafter, the Secretary shall publish a list of covered home intravenous drugs that may be used in conjunction with the provision of home intravenous drug therapy services under this title.

''(4) The term 'qualified home intravenous drug therapy provider' means any entity that the Secretary determines meets the following requirements:

''(i) The entity is capable of providing or arranging for the items and services described in paragraph (2) of this subsection and covered home intravenous drugs.

''(ii) The entity maintains clinical records for each patient.

''(iii) The entity adheres to written protocols and policies with respect to the provision of items and services.

''(iv) The entity makes services available, as needed, 7 days a week on a 24-hour basis.

''(v) The entity coordinates all services provided to a patient with the physician of such patient.

''(vi) The entity conducts a quality assessment and assurance program, including a drug regimen review and the coordination of patient care.

''(vii) The entity assures that only trained personnel provide—

''(A) covered home intravenous drugs; and

''(B) any other service for which training is required to safely provide the service.

''(viii) The entity assumes responsibility for the quality of services provided by another person under arrangements with a State agency (or the appropriate agency or department of a political subdivision of a State) or the entity.

''(ix) In the case where the State or a political subdivision of the State in which the entity operates has a licensing program applicable to such entity, such entity—

''(A) is licensed pursuant to applicable laws; or

''(B) has been approved by the State agency or department (or the appropriate agency or department of the political subdivision of the State) responsible for conducting such licensing

program as meeting the standards for licensing under such program.

''(x) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of such services under this title.''.

(c) PAYMENT.—

(1) IN GENERAL.—Part B of title XVIII of such Act (42 U.S.C. 1395j et seq.) is amended—

(A) in section 1833—

(i) in paragraph (2) of subsection (a)—

(I) in subparagraph (D), by striking ''and'' at the end of the subparagraph;

(II) in subparagraph (E), by striking the semicolon and inserting ''; and''; and

(III) by adding at the end of the paragraph the following new subparagraph:

''(F) with respect to home intravenous drug therapy services, the amounts described in section 1834(d)(1);''; and

(ii) in subsection (b) of such section, by striking ''services, (3)'' and inserting ''services and home intravenous drug therapy services, (3)''; and

(B) by adding at the end of section 1834, the following new subsection:

''(d) HOME INTRAVENOUS DRUG THERAPY SERVICES.—

''(1) IN GENERAL.—With respect to home intravenous drug therapy services, payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee determined under the fee schedule established under paragraph (2).

''(2) ESTABLISHMENT OF FEE SCHEDULE.—Not later than January 1, 1994, and annually thereafter, the Secretary shall establish by regulation, with respect to each calendar year, a fee schedule for home intravenous drug therapy services for which payment is made under this part. Each fee schedule established under this subsection shall be on an illness-specific basis.''.

(d) CERTIFICATION.—

(1) IN GENERAL.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)), as amended by section 311(d) of this Act, is further amended—

(A) by striking ''and'' at the end of subparagraph (F);

(B) by inserting ''and'' at the end of subparagraph (G); and

(C) by inserting after subparagraph (G) the following new subparagraph:

''(H) in the case of home intravenous drug therapy services—

''(i) such services are or were required because the individual needed such services for the administration of a covered home intravenous drug;

''(ii) a plan for furnishing such services has been established and is reviewed periodically by a physician;

''(iii) such services are or were furnished while the individual is or was under the care of a physician;

''(iv) such services are administered in a place or residence used as the home of such individual; and

''(v) with respect to such services initiated before January 1, 1996, such services have been reviewed and approved by a utilization and peer review organization under section 1154(a)(16) before the date such services were initiated (or, in the case of services initiated on an outpatient basis, within 1 working day (as used in section 1154) of the date of initiation of the services, except in exceptional circumstances, as determined by the Secretary).''.

(2) PRIOR APPROVAL REQUIRED.—Section 1154(a) of such Act (42 U.S.C. 1320-c3(a)), is amended by adding at the end the following new paragraph:

''(16) The organization shall conduct a review described in paragraph (1) with respect to home intravenous drug therapy services (as defined in section 1861(ll)(1)) initiated before January 1, 1996, within 1 working day of the date of the receipt of a request for such review. The Secretary shall establish criteria to be used by the organization in conducting a review of the appropriateness of home intravenous drug therapy services pursuant to this paragraph.''.

(e) CERTIFICATION OF HOME INTRAVENOUS DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) of such Act (42 U.S.C. 1395x(u)) is amended by inserting ''qualified home intravenous drug therapy provider,'' after ''hospice program,''.

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 of such Act (42 U.S.C. 1395z), is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), and (ll)(4)''.

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) of such Act (42 U.S.C. 1395aa(a)), as amended by section 4163(c)(2) of the Omnibus Budget Reconciliation Act of 1990, is amended—

(A) in the first sentence, by inserting ''or a qualified home intravenous drug therapy provider,'' after ''hospice program'', and

(B) in the second sentence, by striking ''or hospice program'' and inserting ''hospice program, or qualified home intravenous drug therapy provider''.

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 of such Act (42 U.S.C.

1395w-2), as amended by section 4154(e)(2) of the Omnibus Budget Reconciliation Act of 1990, is amended—

(A) in the heading, by adding at the end ''AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS'';

(B) in subsection (a), by inserting ''or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements described in clauses (i) through (x) of section 1861(ll)(4)'' after ''under this part''; and

(C) in subsection (b)(2)(A)(iv), by inserting ''or home intravenous drug therapy service'' after ''clinical diagnostic laboratory tests''.

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 of such Act (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(k) With respect to carrying out functions relating to payment for home intravenous drug therapy services, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1994.

SEC. 313. EXTENDING HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: ''For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.''.

(b) PAYMENT UNDER PART B.—Section 1833(d) of such Act (42 U.S.C. 1395l(d)) is amended—

(1) by striking ''(d) No payment'' and inserting ''(d)(1) Except as provided in paragraph (2), no payment''; and

(2) by adding at the end the following new paragraph:

''(2) In the case of home health services furnished to an individual enrolled under this part for which payment is made only as a result of the application of the

last sentence of section 1861(m), payment shall be made under this part.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished in cases of initial periods of home health services beginning on or after January 1, 1994.

Subtitle C—Senior Health Insurance Consumer Protection

SEC. 321. CERTIFICATION OF HEALTH INSURANCE POLICIES FOR THE ELDERLY.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall no later than 90 days after the date of enactment of this Act establish a procedure whereby health insurance policies for the elderly may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (b). Such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to verify independently the accuracy of such notarized statement. Where the Secretary determines such policy meets (or continues to meet) such standards and requirements, the Sec-

retary shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may require) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received the Secretary's certification.

(b) CERTIFICATION AND REQUIREMENTS.—The Secretary shall certify under this section any health insurance policies for the elderly, or continue certification of such a policy, only if the Secretary finds that such policy—

(1) meets or exceeds the National Association of Insurance Commissioners Model Act Standards;

(2) is guaranteed to be renewable on the basis of the same premium rate (or, if a different rate, a rate that is adjusted on a class basis);

(3) limits the exclusion of preexisting conditions in accordance with regulations prescribed by the Secretary;

(4) allows any purchaser 30 days to rescind the purchase of the policy by such purchaser;

(5) provides that policies of such health insurance be written in simplified language which can be

understood by purchasers, as specified in regulations prescribed by the Secretary; and

(6) meets or exceeds such other requirements as the Secretary (in consultation with State commissioners or superintendents of insurance) shall by regulation prescribe.

(c) STUDY AND REPORT.—The Secretary shall 3 years after the date of enactment of this Act conduct a study and issue a report to Congress on health insurance policies for the elderly. Such study and report shall be conducted and issued no later than 6 months after the 3-year period commencing after the date of enactment of this Act.

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S 728 IS——5

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